BEFORE THE
PHYSICIAN ASSISTANT BOARD
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against:	)	
STANTON HERRICK BROWN, P.A.	)	Case No. 950-2017-001498
Physician Assistant License No. PA 11937	)	
Respondent	)	

DECISION AND ORDER

The attached Stipulated Surrender of License and Order is hereby adopted as the Decision and Order of the Physician Assistant Board, Department of Consumer Affairs, State of California.

This Decision shall become effective at 5:00 p.m. on September 24, 2020.

IT IS SO ORDERED September 17, 2020.

PHYSICIAN ASSISTANT BOARD

By: _____
Rozana Khan
Interim Executive Officer

XAVIER BECERRA
Attorney General of California
STEVE DIEHL
Supervising Deputy Attorney General
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Attorneys for Complainant

BEFORE THE
PHYSICIAN ASSISTANT BOARD
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **STANTON HERRICK BROWN, P.A.** **10643 N. Laurel Valley Dr.** **Fresno, CA 93720** **Physician Assistant License No. PA 11937** Respondent.	Case No. 950-2017-001498 **STIPULATED SURRENDER OF LICENSE AND ORDER**

IT IS HEREBY STIPULATED AND AGREED by and between the parties to the above-entitled proceedings that the following matters are true:

PARTIES

1. Rozana Khan (Complainant)[1] is the Interim Executive Officer of the Physician Assistant Board (Board). She brings this action solely in her official capacity and is represented in this matter by Xavier Becerra, Attorney General of the State of California, by Michael C. Brummel, Deputy Attorney General.

2. Stanton Herrick Brown, P.A. (Respondent) is representing himself in this proceeding and has chosen not to exercise his right to be represented by counsel.

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[1] The action was brought by former Executive Officer Maureen L. Forsyth. Rozana Khan became Interim Executive Officer effective September 1, 2020.

3. On or about March 16, 1987, the Board issued Physician Assistant License No. PA 11937 to Stanton Herrick Brown, P.A. (Respondent). The Physician Assistant License was in full force and effect at all times relevant to the charges brought in Accusation No. 950-2017-001498 and will expire on March 31, 2021, unless renewed.

JURISDICTION

4. Accusation No. 950-2017-001498 was filed before the Board, and is currently pending against Respondent. The Accusation and all other statutorily required documents were properly served on Respondent on July 8, 2020. Respondent timely filed his Notice of Defense contesting the Accusation. A copy of Accusation No. 950-2017-001498 is attached as Exhibit A and incorporated by reference.

ADVISEMENT AND WAIVERS

5. Respondent has carefully read, and understands the charges and allegations in Accusation No. 950-2017-001498. Respondent also has carefully read, and understands the effects of this Stipulated Surrender of License and Order.

6. Respondent is fully aware of his legal rights in this matter, including the right to a hearing on the charges and allegations in the Accusation; the right to be represented by counsel, at his own expense; the right to confront and cross-examine the witnesses against him; the right to present evidence and to testify on his own behalf; the right to the issuance of subpoenas to compel the attendance of witnesses and the production of documents; the right to reconsideration and court review of an adverse decision; and all other rights accorded by the California Administrative Procedure Act and other applicable laws.

7. Respondent voluntarily, knowingly, and intelligently waives and gives up each and every right set forth above.

CULPABILITY

8. Respondent understands that the charges and allegations in Accusation No. 950-2017-001498, if proven at a hearing, constitute cause for imposing discipline upon his Physician Assistant License.

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9. For the purpose of resolving the Accusation without the expense and uncertainty of further proceedings, Respondent agrees that, at a hearing, Complainant could establish a factual basis for the charges in the Accusation and that those charges constitute cause for discipline. Respondent hereby gives up his right to contest that cause for discipline exists based on those charges.

10. Respondent agrees that if he ever petitions for reinstatement of his Physician Assistant License No. PA 11937, all of the charges and allegations contained in Accusation No. 950-2017-001498 shall be deemed true, correct and fully admitted by Respondent for purposes of that reinstatement proceeding or any other licensing proceeding involving respondent in the State of California.

11. Respondent understands that by signing this stipulation he enables the Board to issue an order accepting the surrender of his Physician Assistant License without further process.

CONTINGENCY

12. This stipulation shall be subject to approval by the Board. Respondent understands and agrees that counsel for Complainant and the staff of the Board may communicate directly with the Board regarding this stipulation and surrender, without notice to or participation by Respondent. By signing the stipulation, Respondent understands and agrees that he may not withdraw his agreement or seek to rescind the stipulation prior to the time the Board considers and acts upon it. If the Board fails to adopt this stipulation as its Decision and Order, the Stipulated Surrender and Disciplinary Order shall be of no force or effect, except for this paragraph, it shall be inadmissible in any legal action between the parties, and the Board shall not be disqualified from further action by having considered this matter.

13. The parties understand and agree that Portable Document Format (PDF) and facsimile copies of this Stipulated Surrender of License and Order, including PDF and facsimile signatures thereto, shall have the same force and effect as the originals.

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14. In consideration of the foregoing admissions and stipulations, the parties agree that the Board may, without further notice or formal proceeding, issue and enter the following Order:

ORDER

IT IS HEREBY ORDERED that Physician Assistant License No. PA 11937, issued to Respondent Stanton Herrick Brown, P.A., is surrendered and accepted by the Board.

1. The surrender of Respondent's Physician Assistant License and the acceptance of the surrendered license by the Board shall constitute the imposition of discipline against Respondent. This stipulation constitutes a record of the discipline and shall become a part of Respondent's license history with the Board.

2. Respondent shall lose all rights and privileges as a physician assistant in California as of the effective date of the Board's Decision and Order.

3. Respondent shall cause to be delivered to the Board his pocket license and, if one was issued, his wall certificate on or before the effective date of the Decision and Order.

4. If Respondent ever files an application for licensure or a petition for reinstatement in the State of California, the Board shall treat it as a petition for reinstatement. Respondent must comply with all the laws, regulations and procedures for reinstatement of a revoked or surrendered license in effect at the time the petition is filed, and all of the charges and allegations contained in Accusation No. 950-2017-001498 shall be deemed to be true, correct and admitted by Respondent when the Board determines whether to grant or deny the petition.

5. If Respondent should ever apply or reapply for a new license or certification, or petition for reinstatement of a license, by any other health care licensing agency in the State of California, all of the charges and allegations contained in Accusation, No. 950-2017-001498 shall be deemed to be true, correct, and admitted by Respondent for the purpose of any Statement of Issues or any other proceeding seeking to deny or restrict licensure.

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ACCEPTANCE

I have carefully read the Stipulated Surrender of License and Order. I understand the stipulation and the effect it will have on my Physician Assistant License. I enter into this Stipulated Surrender of License and Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Physician Assistant Board.

DATED: _____

_____
STANTON HERRICK BROWN, P.A.
Respondent

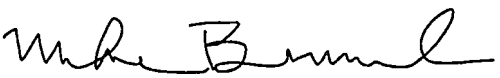
ENDORSEMENT

The foregoing Stipulated Surrender of License and Order is hereby respectfully submitted for consideration by the Physician Assistant Board of the Department of Consumer Affairs.

DATED: September 14, 2020

Respectfully submitted,

XAVIER BECERRA
Attorney General of California
STEVE DIEHL
Supervising Deputy Attorney General



MICHAEL C. BRUMMEL
Deputy Attorney General
Attorneys for Complainant

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ACCEPTANCE

I have carefully read the Stipulated Surrender of License and Order. I understand the stipulation and the effect it will have on my Physician Assistant License. I enter into this Stipulated Surrender of License and Order voluntarily, knowingly, and intelligently, and agree to be bound by the Decision and Order of the Physician Assistant Board.

DATED: 9/4/2020

STANTON HERRICK BROWN, P.A.
Respondent

ENDORSEMENT

The foregoing Stipulated Surrender of License and Order is hereby respectfully submitted for consideration by the Physician Assistant Board of the Department of Consumer Affairs.

DATED: _____

Respectfully submitted,

XAVIER BECERRA
Attorney General of California
STEVE DIEHL
Supervising Deputy Attorney General

MICHAEL C. BRUMMEL
Deputy Attorney General
Attorneys for Complainant

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Exhibit A

Accusation No. 950-2017-001498

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Attorney General of California
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Supervising Deputy Attorney General
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Attorneys for Complainant

BEFORE THE
PHYSICIAN ASSISTANT BOARD
DEPARTMENT OF CONSUMER AFFAIRS
STATE OF CALIFORNIA

In the Matter of the Accusation Against: **Stanton Herrick Brown, P.A.** **10643 N. Laurel Valley Dr.** **Fresno, CA 93720** **Physician Assistant License No. PA 11937,** Respondent.	Case No. 950-2017-001498 A C C U S A T I O N

PARTIES

1. Maureen L. Forsyth (Complainant) brings this Accusation solely in her official capacity as the Executive Officer of the Physician Assistant Board, Department of Consumer Affairs (Board).

2. On or about March 16, 1987, the Physician Assistant Board issued Physician Assistant License No. PA 11937 to Stanton Herrick Brown, P.A. (Respondent). The Physician Assistant License was in full force and effect at all times relevant to the charges brought herein

and will expire on March 31, 2021, unless renewed.

JURISDICTION

3. This Accusation is brought before the Board, under the authority of the following laws. All section references are to the Business and Professions Code (Code) unless otherwise indicated.

4. Section 3527 of the Code states, in pertinent part:

> (a) The board may order the denial of an application for, or the issuance subject to terms and conditions of, or the suspension or revocation of, or the imposition of probationary conditions upon a physician assistant license after a hearing as required in Section 3528 for unprofessional conduct that includes, but is not limited to, a violation of this chapter, a violation of the Medical Practice Act, or a violation of the regulations adopted by the board or the Medical Board of California.
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> ...
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> (e) The board may order the licensee to pay the costs of monitoring the probationary conditions imposed on the license.
>
> (f) The expiration, cancellation, forfeiture, or suspension of a physician assistant license by operation of law or by order or decision of the board or a court of law, the placement of a license on a retired status, or the voluntary surrender of a license by a licensee shall not deprive the board of jurisdiction to commence or proceed with any investigation of, or action or disciplinary proceeding against, the licensee or to render a decision suspending or revoking the license.

5. Section 2234 of the Code, states:

> The board shall take action against any licensee who is charged with unprofessional conduct. In addition to other provisions of this article, unprofessional conduct includes, but is not limited to, the following:
>
> (a) Violating or attempting to violate, directly or indirectly, assisting in or abetting the violation of, or conspiring to violate any provision of this chapter.
>
> (b) Gross negligence.
>
> (c) Repeated negligent acts. To be repeated, there must be two or more negligent acts or omissions. An initial negligent act or omission followed by a separate and distinct departure from the applicable standard of care shall constitute repeated negligent acts.
>
> (1) An initial negligent diagnosis followed by an act or omission medically appropriate for that negligent diagnosis of the patient shall constitute a single negligent act.

(2) When the standard of care requires a change in the diagnosis, act, or omission that constitutes the negligent act described in paragraph (1), including, but not limited to, a reevaluation of the diagnosis or a change in treatment, and the licensee's conduct departs from the applicable standard of care, each departure constitutes a separate and distinct breach of the standard of care.

(d) Incompetence.

(e) The commission of any act involving dishonesty or corruption which is substantially related to the qualifications, functions, or duties of a physician and surgeon.

(f) Any action or conduct which would have warranted the denial of a certificate.

(g) The failure by a certificate holder, in the absence of good cause, to attend and participate in an interview by the board. This subdivision shall only apply to a certificate holder who is the subject of an investigation by the board.

6. Section 2266 of the Code states: The failure of a physician and surgeon to maintain adequate and accurate records relating to the provision of services to their patients constitutes unprofessional conduct.

COST RECOVERY

7. Section 125.3 of the Code states:

(a) Except as otherwise provided by law, in any order issued in resolution of a disciplinary proceeding before any board within the department or before the Osteopathic Medical Board, upon request of the entity bringing the proceeding, the administrative law judge may direct a licensee found to have committed a violation or violations of the licensing act to pay a sum not to exceed the reasonable costs of the investigation and enforcement of the case.

(b) In the case of a disciplined licentiate that is a corporation or a partnership, the order may be made against the licensed corporate entity or licensed partnership.

(c) A certified copy of the actual costs, or a good faith estimate of costs where actual costs are not available, signed by the entity bringing the proceeding or its designated representative shall be prima facie evidence of reasonable costs of investigation and prosecution of the case. The costs shall include the amount of investigative and enforcement costs up to the date of the hearing, including, but not limited to, charges imposed by the Attorney General.

(d) Tbe administrative law judge shall make a proposed finding of the amount of reasonable costs of investigation and prosecution of the case when requested pursuant to subdivision (a). The finding of tbe administrative law judge with regard to costs shall not be reviewable by the board to increase the cost award. The board may

reduce or eliminate the cost award, or remand to the administrative law judge if the proposed decision fails to make a finding on costs requested pursuant to subdivision (a).

(e) If an order for recovery of costs is made and timely payment is not made as directed in the board's decision, the board may enforce the order for repayment in any appropriate court. This right of enforcement shall be in addition to any other rights the board may have as to any licensee to pay costs.

(f) In any action for recovery of costs, proof of the board's decision shall be conclusive proof of the validity of the order of payment and the terms for payment.

(g) (1) Except as provided in paragraph (2), the board shall not renew or reinstate the license of any licentiate who has failed to pay all of the costs ordered under this section.

(2) Notwithstanding paragraph (1), the board may, in its discretion, conditionally renew or reinstate for a maximum of one year the license of any licensee who demonstrates financial hardship and who enters into a formal agreement with the board to reimburse the board within that one-year period for the unpaid costs.

(h) All costs recovered under this section shall be considered a reimbursement for costs incurred and shall be deposited in the fund of the board recovering the costs to be available upon appropriation by the Legislature.

(i) Nothing in this section shall preclude a board from including the recovery of the costs of investigation and enforcement of a case in any stipulated settlement.

(j) This section does not apply to any board if a specific statutory provision in that board's licensing act provides for recovery of costs in an administrative disciplinary proceeding.

(k) Notwithstanding the provisions of this section, the Medical Board of California shall not request nor obtain from a physician and surgeon, investigation and prosecution costs for a disciplinary proceeding against the licensee. The board shall ensure that this subdivision is revenue neutral with regard to it and that any loss of revenue or increase in costs resulting from this subdivision is offset by an increase in the amount of the initial license fee and the biennial renewal fee, as provided in subdivision (e) of Section 2435.

DEFINITIONS

PERTINENT DRUGS AND DEFINITIONS

8. Controlled Substance Utilization Review and Evaluation System 2.0 (CURES) is a database of Schedule II, III, and IV controlled substance prescriptions dispensed in California serving the public health, regulatory and oversight agencies and law enforcement. CURES 2.0 is

committed to the reduction of prescription drug abuse and diversion without affecting legitimate medical practice or patient care.

9. Controlled Substances Agreement, also known as a pain management contract or pain management agreement. A pain management agreement is recommended for patients on short-acting opioids at the time of the third visit; on long acting opioids; or expected to require more than three months of opioids. A pain management agreement outlines the responsibilities of the physician and patient during the time that controlled substances are prescribed. See Medical Board of California: Guidelines for Prescribing Controlled Substances for Pain, November 2014.

10. Acetaminophen (Tylenol®) is a pain reliever and a fever reducer. It is used to treat many conditions including headache, muscle aches, arthritis, backache, toothaches, colds, and fevers. Acetaminophen is not a controlled substance.

11. Acetaminophen and hydrocodone bitartrate (Vicodin® and Norco®) is an opioid pain medication used for relief from moderate to moderately severe pain and has a high potential for abuse. Norco is a Schedule II controlled substance pursuant to Health and Safety Code section 11055, subdivision (e), and a dangerous drug pursuant to Business and Professions Code section 4022.

12. Acetaminophen and oxycodone (Endocet®, Percocet®, Roxicet®) is a combination of two medicines used to treat moderate to severe pain. Oxycodone is an opioid pain medication, commonly referred to as a narcotic. Acetaminophen is a less potent pain reliever that increases the effects of oxycodone. Oxycodone has a high potential for abuse. Oxycodone is a Schedule II controlled substance and narcotic as defined by section 11055, subdivision (b)(1) of the Health and Safety Code, and a Schedule II controlled substance as defined by Section 1308.12 (b)(1) of Title 21 of the code of Federal Regulations and a dangerous drug as defined in Business and Professions Code section 4022. Respiratory depression is the chief hazard from all opioid agonist preparations. Oxycodone should be used with caution and started in a reduced dosage (1/3 to 1/2 of the usual dosage) in patients who are concurrently receiving other central nervous system depressants including sedatives or hypnotics, general anesthetics, phenothiazines, other tranquilizers and alcohol.

13. Belsomra® (suvorexant) is a sleep medicine used to treat insomnia that has some potential for abuse. Belsomra® is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

14. Benzodiazepines are a class of agents that work on the central nervous system, acting on select receptors in the brain that inhibit or reduce the activity of nerve cells within the brain. Valium, diazepam, alprazolam and temazepam are all examples of benzodiazepines. All benzodiazepines are Schedule IV controlled substances and have the potential for abuse, addiction and diversion.

15. Carisoprodol (Soma) a muscle relaxant medication used to treat musculoskeletal pain. Side effects include headache, dizziness, and sleepiness. Carisoprodol is a Schedule IV controlled substance.

16. Fentanyl is an opioid skin patch that is used to treat severe chronic pain. Fentanyl has a high potential for abuse. Fentanyl is a Schedule II controlled substance and narcotic as defined by section 11055, subdivision (b)(1) of the Health and Safety Code, and a Schedule II controlled substance as defined by Section 1308.12 (b)(1) of Title 21 of the code of Federal Regulations and a dangerous drug as defined in Business and Professions Code section 4022.

17. Flurazepam is in the class of benzodiazepine medications. It affects chemicals in the brain that may be unbalanced in people with anxiety. Flurazepam is used to treat anxiety disorders, panic disorders and anxiety caused by depression. Flurazepam has the potential for abuse. Flurazepam is a Schedule IV controlled substance pursuant to health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

18. Hydromorphone (Dilaudid®) is an opioid pain medication commonly called a narcotic that is used to treat moderate to severe pain. Dilaudid can slow or stop your breathing and should not be used in larger amounts or longer periods than prescribed. Dilaudid may be habit-forming and can cause addiction, overdose or death if misused. Dilaudid has a high potential for abuse. Dilaudid is a Schedule II controlled substance under Health and Safety Code

section 11055, and a Schedule II controlled substance under section 1308.12 of Title 21 of the Code of Federal Regulations and a dangerous drug as defined in Business and Professions Code section 4022.

19. Kenalog® (triamcinolone) is a steroid that prevents the release of substances in the body that cause inflammation. It is used to treat many different types of inflammatory conditions, including severe allergic reactions, skin disorders, severe colitis, inflammation of the joints or tendons, blood cell disorders, inflammatory eye disorders, lung disorders, and problems caused by low adrenal gland hormones. It is a dangerous drug as defined in Business and Professions Code section 4022.

20. Marcaine HCl® (bupivacaine) is an anesthetic that blocks nerve impulses in the body, used as a local anesthetic. It is given as an epidural injection into the spinal column to produce numbness during labor, surgery, or certain medical procedures. It is also used during dental procedures. It is a dangerous drug as defined in Business and Professions Code section 4022.

21. Methadone is an opioid medication that has a high potential for abuse. It is a dangerous drug as defined in section 4022 and a Schedule II controlled substance and narcotic as defined by section 11055 of the Health and Safety Code. Methadone is used as a pain reliever and as part of drug addiction detoxification and maintenance programs. It may cause a prolonged QT interval (a rare heart problem that may cause irregular heartbeat, fainting, or sudden death).

22. "MME" is an abbreviation for the Morphine Milligram Equivalents used to evaluate the levels of opioids prescribed to a patient. The CDC recommends avoiding or carefully justifying any dosage greater than 90 MME/day.

23. Morphine (MS Contin®) is an opioid pain medication or narcotic that is used to treat pain. It can be taken as needed for pain in short acting formulations or as an extended-release form for constant pain depending upon the formulation. Morphine has a high potential for abuse. Morphine is a Schedule II controlled substance under Health and Safety Code section 11055, and a Schedule II controlled substance under section 1308.12 of Title 21 of the Code of Federal Regulations and a dangerous drug as defined in Business and Professions Code section 4022.

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24. Nucynta® (tapentadol hydrochloride) is an opioid pain medication or narcotic that is used to treat moderate to severe pain. Nucynta® has a high potential for abuse. Nucynta® is a Schedule II controlled substance and narcotic as defined by section 11055, subdivision (b)(1) of the Health and Safety Code, and a Schedule II controlled substance as defined by Section 1308.12 (b)(1) of Title 21 of the Code of Federal Regulations and a dangerous drug as defined in Business and Professions Code section 4022.

25. Oxycodone (Oxaydo®, OxyCONTIN®, Oxyfast®, Roxicodon®, Xtampza ER®) is a white odorless crystalline power derived from an opium alkaloid. It is a pure agonist opioid whose principal therapeutic action is analgesia. Other therapeutic effects of Oxycodone include anxiolysis, euphoria and feelings of relaxation. Oxycodone has a high potential for abuse. Oxycodone is a Schedule II controlled substance and narcotic as defined by section 11055, subdivision (b)(1) of the Health and Safety Code, and a Schedule II controlled substance as defined by Section 1308.12 (b)(1) of Title 21 of the code of Federal Regulations and a dangerous drug as defined in Business and Professions Code section 4022. Respiratory depression is the chief hazard from all opioid agonist preparations. Oxycodone should be used with caution and started in a reduced dosage (1/3 to 1/2 of the usual dosage) in patients who are concurrently receiving other central nervous system depressants including sedatives or hypnotics, general anesthetics, phenothiazines, other tranquilizers and alcohol.

26. Temazepam (Restoril®) is a benzodiazepine medication that affects chemicals in the brain that may be unbalanced in people with sleep problems. Temazepam is used to treat insomnia symptoms and has the potential for abuse. Temazepam is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

27. Tramadol (Ultram®) is a narcotic like pain reliever used to treat severe pain. Tramadol has the potential for abuse. Tramadol is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

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28. Xanax® (alprazolam) is in the class of benzodiazepine medications. It affects chemicals in the brain that may be unbalanced in people with anxiety. Xanax is used to treat anxiety disorders, panic disorders and anxiety caused by depression. Xanax has the potential for abuse. Xanax is a Schedule IV controlled substance pursuant to health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022.

29. Zolpidem tartrate (Ambien®) is a Schedule IV controlled substance pursuant to Health and Safety Code section 11057, subdivision (d), and a dangerous drug pursuant to Business and Professions Code section 4022. It is a sedative used to treat insomnia and has potential for abuse.

FIRST CAUSE FOR DISCIPLINE

(Repeated Negligent Acts)

30. Respondent's Physician Assistant License No. PA 11937 is subject to disciplinary action under section 3527, as defined by section 2234, subdivision (b), in that he committed act(s) and/or omission(s) constituting negligence. The circumstances are as follows:

31. At all times relevant herein, Respondent practiced in an outpatient clinic specializing in primary care and/or family medicine. Respondent reports treating approximately 25 patients each day, including adults and pediatrics. Respondent is supervised by a physician and surgeon, pursuant to a delegation of services agreement.

Patient A[1]

2016

32. On or about January 22, 2016, Patient A presented to Respondent complaining of bilateral ear pain, and seeking a refill of her anxiety medications. Respondent prescribed an antibiotic for her ear, and refilled her prescription for alprazolam.

33. On or about February 9, 2016, Patient A presented to Respondent. In the physical examination section of the medical record, Respondent wrote that Patient A "[d]emonstrated good judgment and reason and normal affect during examination." Respondent repeated this

[1] To protect the privacy of the patients, names are not identified in this Accusation.

psychiatric physical examination finding verbatim on approximately 37 separate examinations through January 9, 2019.

34. On or about September 16, 2016, Patient A presented to Respondent complaining of ear pain, runny nose, cough, and a sore throat for the prior three days. Patient A reported that her pain level was a 6/10, and that she needed refills of Tramadol and Xanax. Respondent documented a psychiatric evaluation that revealed "good judgment and reason and normal affect," but diagnosed her with unspecified anxiety disorder. Respondent documented bruising to Patient A's left lower ribs, but did not document a musculoskeletal examination. Respondent did not document any assessment of Patient A's anxiety at this visit by a specific psychometric tool or an examination. Respondent prescribed alprazolam 2 mg, a short acting benzodiazepine, three times daily. Patient A received concurrent prescriptions for alprazolam, tramadol, hydrocodone and carisoprodol.

35. On or about October 20, 2016, Patient A returned to the same clinic, and was seen by another provider. A behavior health referral was made, a urine drug screen was performed, and the provider reviewed Patient A's CURES without identifying any abnormalities. The provider noted that the prescriptions for alprazolam and tramadol were only intended to be temporary, and that they would begin to taper the prescriptions for controlled substances. Patient A participated in a urine drug screen that was positive for the presence of amphetamines and methamphetamines.

36. On or about December 6, 2016, Patient A returned to the clinic with the chief complaint listed only as "refills." In the history of present illness, Respondent noted that Patient A has a history of methamphetamine use and manipulative behavior. Respondent documented that Patient A presented complaining of an ingrown toenail, chronic psoriasis, chronic pain associated with a neck injury from three months prior, and was acting hyperactive at this visit. In the psychiatric examination, Respondent documented that Patient A demonstrated good judgment, reason, and normal affect during the examination.

37. In 2016, Patient A presented to Respondent's clinic for treatment approximately 28 times, meeting with Respondent approximately 8 times.

38. During the period of on or about June 23, 2016 through December 6, 2016, Patient A filled the following prescriptions for controlled substances:

Date Filled	Drug Name	Form	Drug Strength	Qty	Days Supply	Prescriber Name
6/23/16	TRAMADOL HCL	TAB	50 MG	90	22	M.K., M.D.
6/30/16	ALPRAZOLAM	TAB	2 MG	90	30	M.K., M.D.
6/30/16	HYDROCODONE BITARTRATE-ACETAMINOPHEN	TAB	325 MG-10 MG	90	22	M.K., M.D.
7/21/16	TRAMADOL HCL	TAB	50 MG	90	22	M.K., M.D.
7/28/16	ALPRAZOLAM	TAB	2 MG	90	30	M.K., M.D.
7/28/16	HYDROCODONE BITARTRATE-ACETAMINOPHEN	TAB	325 MG-10 MG	90	22	M.K., M.D.
8/11/16	TRAMADOL HCL	TAB	50 MG	90	22	M.K., M.D.
8/25/16	ALPRAZOLAM	TAB	2 MG	90	30	M.K., M.D.
8/25/16	HYDROCODONE BITARTRATE-ACETAMINOPHEN	TAB	325 MG-10 MG	90	22	M.K., M.D.
9/16/16	TRAMADOL HCL	TAB	50 MG	90	22	Respondent
9/19/16	ALPRAZOLAM	TAB	2 MG	90	30	Respondent
9/22/16	HYDROCODONE BITARTRATE-ACETAMINOPHEN	TAB	325 MG-10 MG	90	22	M.K., M.D.
10/20/16	ALPRAZOLAM	TAB	2 MG	90	30	M.K., M.D.
10/20/16	HYDROCODONE BITARTRATE-ACETAMINOPHEN	TAB	325 MG-10 MG	90	22	M.K., M.D.
10/20/16	TRAMADOL HCL	TAB	50 MG	90	15	M.K., M.D.
12/6/16	ALPRAZOLAM	TAB	2 MG	90	30	Respondent
12/6/16	HYDROCODONE BITARTRATE-ACETAMINOPHEN	TAB	325 MG-10 MG	90	22	Respondent
12/6/16	TRAMADOL HCL	TAB	50 MG	90	15	Respondent

2017

39. On or about January 3, 2017, Patient A returned to Respondent for treatment complaining of bilateral ear pain, pain at a level of 9/10, and requesting refills. Respondent noted that Patient A's toxicology screen was positive for amphetamine and that he would not prescribe any alprazolam. The records state that Patient A has a pending referral to "chronic pain doctor."

40. On or about January 26, 2017, Patient A returned to the clinic and was seen by another provider, who noted that she would not prescribe Patient A any Xanax due to Patient A's recent positive toxicology result amphetamine. The records note that Patient A was "upset" about the refusal to prescribe Xanax at this visit.

41. On or about March 3, 2017, Patient A returned to the clinic and was treated by Respondent. Despite the prior amphetamine result, and the other medical provider's refusal to fill the Xanax prescription, Respondent refilled Patient A's prescription for Xanax.

42. On or about March 24, 2017, Patient A returned to Respondent complaining of an abscess in her buttocks that was draining for the past two weeks, and seeking refills related to her chronic pain. In the section of the medical record for the musculoskeletal examination, Respondent wrote "[n]o joint deformity, erythema, or tenderness. Full ROM all joints. Normal gait." Respondent prescribed gabapentin and carisoprodol to Patient A for her chronic pain.

43. On or about April 19, 2017, Patient A participated in a urine drug screen that was positive for the presence of amphetamines and methamphetamines.

44. On or about September 15, 2017, Respondent prescribed lorazepam to Patient A, which overlapped with her concurrent prescriptions of carisoprodol and alprazolam.

45. On or about November 30, 2017, Patient A presented to Respondent for medication reconciliation. The history of present illness states that Patient A was recently released from a psychiatric ward for new onset schizophrenia after acting "rowdy" at home and hearing voices. Patient A was seeking a refill on her medications, as well as referrals to a psychiatrist for schizophrenia, and a neurologist for narcolepsy. Despite the patient's recent diagnosis and hospitalization, Respondent continued to note the psychiatric section of the physical examination verbatim as, "[d]emonstrated good judgment and reason and normal affect during examination." Respondent prescribed a long acting benzodiazepine, Clonazepam 2mg, three times daily. Respondent continued to prescribe Clonazepam to Patient A through 2019.

46. In 2017, Patient A presented to Respondent's clinic for treatment approximately 17 times, meeting with Respondent approximately 14 times.

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47. During the period of on or about January 3, 2017 through November 30, 2017, Patient A filled the following prescriptions for controlled substances:

Date Filled	Drug Name	Form	Drug Strength	Qty	Days' Supply	Prescriber Name
1/3/17	ALPRAZOLAM	TAB	2 MG	90	30	Respondent
3/3/17	ALPRAZOLAM	TAB	2 MG	90	30	Respondent
3/24/17	CARISOPRODOL	TAB	350 MG	42	14	Respondent
4/18/17	ALPRAZOLAM	TAB	2 MG	90	30	Respondent
5/23/17	ALPRAZOLAM	TAB	2 MG	90	30	Respondent
6/20/17	ALPRAZOLAM	TAB	2 MG	90	30	Respondent
6/20/17	CARISOPRODOL	TAB	350 MG	42	14	Respondent
7/14/17	ALPRAZOLAM	TAB	2 MG	90	30	J.C., M.D.
8/8/17	ALPRAZOLAM	TAB	2 MG	90	30	Respondent
9/5/17	ALPRAZOLAM	TAB	2 MG	90	30	Respondent
9/15/17	LORAZEPAM	TAB	1 MG	24	8	Respondent
9/26/17	CARISOPRODOL	TAB	350 MG	42	14	Respondent
9/29/17	ALPRAZOLAM	TAB	2 MG	90	30	Respondent
11/1/17	ALPRAZOLAM	TAB	2 MG	90	30	Respondent
11/28/17	CLONAZEPAM	TAB	0.5 MG	30	15	A.V., M.D.
11/30/17	CLONAZEPAM	TAB	2 MG	90	30	Respondent

2018

48. On or about February 20, 2018, Patient A presented to Respondent for medication reconciliation, and complaining of cough and sinus pressure. Patient A told Respondent that she hears voices, and falls asleep when walking and driving.

49. In 2018, Patient A presented to Respondent's clinic for treatment approximately 18 times, meeting with Respondent each time.

50. During the period of on or about January 12, 2018 through December 27, 2018, Patient A filled the following prescriptions for controlled substances:

Date Filled	Drug Name	Form	Drug Strength	Qty	Days' Supply	Prescriber Name
1/12/18	CLONAZEPAM	TAB	1 MG	90	30	B.W., M.D.
2/6/18	ALPRAZOLAM	TAB	2 MG	90	30	Respondent
3/8/18	ALPRAZOLAM	TAB	2 MG	90	30	Respondent
4/4/18	CLONAZEPAM	TAB	2 MG	90	30	Respondent

Date Filled	Drug Name	Form	Drug Strength	Qty	Days' Supply	Prescriber Name
6/1/18	CLONAZEPAM	TAB	2 MG	90	30	Respondent
6/28/18	CLONAZEPAM	TAB	2 MG	90	30	Respondent
7/30/18	CLONAZEPAM	TAB	2 MG	90	30	Respondent
8/27/18	CLONAZEPAM	TAB	2 MG	90	30	Respondent
9/25/18	CLONAZEPAM	TAB	2 MG	90	30	Respondent
10/25/18	CLONAZEPAM	TAB	2 MG	90	30	Respondent
11/27/18	CLONAZEPAM	TAB	2 MG	90	30	Respondent
12/27/18	CLONAZEPAM	TAB	2 MG	90	30	Respondent

2019

51. During the period of on or about January 1, 2019 through February 28, 2019, Patient A presented to Respondent's clinic for treatment approximately 3 times, meeting with Respondent each time.

52. During the period of on or about January 28, 2019 through June 3, 2019, Patient A filled the following prescriptions for controlled substances:

Date Filled	Drug Name	Form	Drug Strength	Qty	Days' Supply	Prescriber Name
1/28/19	CLONAZEPAM	TAB	2 MG	90	30	Respondent
2/28/19	CLONAZEPAM	TAB	2 MG	90	30	Respondent
3/28/19	CLONAZEPAM	TAB	2 MG	90	30	Respondent
5/3/19	CLONAZEPAM	TAB	2 MG	90	30	Respondent
6/3/19	CLONAZEPAM	TAB	2 MG	90	30	Respondent

Departures: Patient A

53. Despite two toxicology test results that were positive for amphetamines and/or methamphetamines, Respondent did not document a follow up discussion regarding the positive results. Respondent did not document an adequate characterization of Patient A's pain that includes the etiology, location, radiation, intensity, relieving and aggravating factors, or the impact on her quality of life. Respondent typically repeated the findings from prior visits without any change. For example, the physical examination finding consistently stated, "[n]egative except as noted in the HPI," an entry that was repeated at numerous visits without change. Similarly, Respondent's musculoskeletal and psychiatric examinations appear to be an unaltered

template, and are inadequate to evaluate Patient A's complaint of chronic pain, schizophrenia, depression and anxiety. In the physical examinations section of the medical records, Respondent documented Patient A's psychiatric examination as, "[d]emonstrated good judgment and reason and normal affect during examination." Despite the positive toxicology results, inpatient mental health treatment and changes in behavior, Respondent repeated this finding verbatim on approximately 37 separate visits for Patient A without change.

54. Respondent failed to document a physical examination adequate to evaluate and support the patient's diagnoses and conditions, which constitutes a departure from the standard of care. Each visit during which Respondent continued provide treatment to Patient A, absent an adequate documentation of an appropriate physical examination to support the diagnoses and conditions, constitutes a separate departure from the standard of care.

55. Respondent failed to document changes in the physical examination of Patient A as indicated, which constitutes a departure from the standard of care. Each visit during which Respondent continued to provide treatment to Patient A, without documenting changes to her physical examination as indicated, constitutes a separate departure from the standard of care.

56. Respondent failed to utilize a step-wise approach in treatment of Patient A's anxiety. Respondent stated that he prescribed alprazolam to Patient A because it was recommended by his supervising physician. Respondent continued to prescribe alprazolam, a short acting benzodiazepine, that has a greater risk for addiction compared to long acting benzodiazepines, despite the presence of several risk factors. Patient A was diagnosed with new onset schizophrenia, and tested positive for amphetamines on her toxicology tests two times, absent any consideration or modification of the treatment plan of her anxiety by Respondent. Respondent stated that he questioned his supervising physicians about whether to continue the benzodiazepines, but that he was only filling in for them while they were unavailable to treat Patient A. Respondent noted that Patient A complained of excessive daytimes sleepiness, but he did not document consideration of a change in her medications or treatment plan to address this concern. Respondent did not adequately warn Patient A of the potential side effects of continuing to take her controlled substances long term.

57. Respondent failed to question the appropriateness of continuing benzodiazepine treatment, which constitutes a lack of knowledge and a departure from the standard of care.

58. Respondent failed to document the consideration of prescribing non-controlled medications to treat Patient A as an alternative to her controlled medications, which constitutes a lack of knowledge and a departure from the standard of care.

59. Respondent failed to attempt a trial of tapering Patient A off of benzodiazepines after she initiated care with mental health care providers, which constitutes a lack of knowledge and a departure from the standard of care.

60. Respondent failed to document a discussion of the risks and benefits of using controlled substances, possible alternative treatments to the use of controlled substances, and provide a time for questions and answers for Patient A prior to prescribing controlled substances. Respondent's failure to provide Patient A with adequate informed consent related to the prescribing of controlled substances constitutes a departure from the standard of care.

61. Respondent failed to document a periodic review that included a review of the patient's pain, treatment and status, while prescribing opioids and benzodiazepines to Patient A. Respondent's failure to document periodic review for Patient A while prescribing controlled substances constitutes a departure from the standard of care.

Patient B

62. In an interview, Respondent stated that he provided opiates to Patient B for her neck pain. During approximately 33 visits between 2016 and 2019, Respondent's documentation was nearly identical on every occasion, and the physical examinations described patient B as having a normal gait. Respondent stated that Patient B has one leg shorter than the other, with atrophy to her lower left leg. Respondent stated that he did not enter the information into the record that described her as having a normal gait, and that it was put in automatically by the medical record keeping system. Respondent stated that the repeated documentation in the medical records for Patient B that describe her as having no joint deformity, full range of motion, and a normal gait are "not accurate." When asked if he performed the many physical exams on Patient B that are documented in a nearly identical manner, Respondent stated that he did "[m]ost of them."

Respondent claims that the reason he prescribed long term narcotics to Patient B was for her neck condition. The neck condition was not documented by Respondent during Patient B's 33 visits. Respondent stated in an interview that, "I didn't – I should have put that down." Patient B presented to Respondent following her treatment by prior pain management providers. Respondent stated that he directed Patient B to consult with a psychologist and a pain management specialist, but she refused. Respondent could not recall if Patient B signed a pain management agreement, or ever performed a urine drug screen.

2016

63. On or about February 10, 2016, Patient B presented to Respondent complaining of headaches, constipation, and right ankle pain. Respondent prescribed her hydrocodone for pain, along with medications for her headaches and constipation. Respondent recommended that she return to the clinic in one week.

64. In 2016, Patient B presented to Respondent's clinic for treatment approximately 16 times, meeting with Respondent approximately 15 times.

65. During the period of on or about June 23, 2016 through December 6, 2016, Patient A filled the following prescriptions for controlled substances:

Date Filled	Drug Name	Form	Drug Strength	Qty	Days' Supply	Prescriber Name
7/6/2016	HYDROCODONE BITARTRATE-ACETAMINOPHEN	TAB	325 MG-5 MG	60	15	Respondent
7/12/2016	BUTALBITAL-APAP-CAFFEINE-CODEINE	CAP	325 MG-50 MG-40 MG-30 MG	50	8	Respondent
7/12/2016	ZOLPIDEM TARTRATE	TAB	10 MG	30	30	Respondent
7/14/2016	LORAZEPAM	TAB	1 MG	60	30	D.S., M.D.
7/15/2016	HYDROCODONE BITARTRATE-ACETAMINOPHEN	TAB	325 MG-7.5 MG	90	15	D.S., M.D.
8/3/2016	HYDROCODONE BITARTRATE-ACETAMINOPHEN	TAB	325 MG-5 MG	60	15	Respondent
8/9/2016	ACETAMINOPHEN-CODEINE PHOSPHATE	TAB	300 MG-30 MG	50	7	Respondent
8/9/2016	ZOLPIDEM TARTRATE	TAB	10 MG	30	30	Respondent
8/22/2016	ACETAMINOPHEN-CODEINE PHOSPHATE	TAB	300 MG-30 MG	60	5	Respondent
9/6/2016	ZOLPIDEM TARTRATE	TAB	10 MG	30	30	Respondent

Date Filled	Drug Name	Form	Drug Strength	Qty	Days' Supply	Prescriber Name
9/24/2016	OXYCODONE HCL-ACETAMINOPHEN	TAB	325 MG-2.5 MG	40	7	Respondent
10/5/2016	HYDROCODONE BITARTRATE-ACETAMINOPHEN	TAB	325 MG-5 MG	60	15	Respondent
10/27/2016	ACETAMINOPHEN-HYDROCODONE BITARTRATE	TAB	325 MG-5 MG	120	30	Respondent
10/27/2016	ZOLPIDEM TARTRATE	TAB	10 MG	30	30	Respondent
11/23/2016	HYDROCODONE BITARTRATE-ACETAMINOPHEN	TAB	325 MG-5 MG	30	7	Respondent
11/23/2016	ZOLPIDEM TARTRATE	TAB	10 MG	30	30	Respondent
12/5/2016	HYDROCODONE BITARTRATE-ACETAMINOPHEN	TAB	325 MG-5 MG	90	22	Respondent
12/20/2016	HYDROCODONE BITARTRATE-ACETAMINOPHEN	TAB	325 MG-10 MG	60	10	Respondent
12/20/2016	ZOLPIDEM TARTRATE	TAB	10 MG	30	30	Respondent

2017

66. On or about November 27, 2017, Respondent began utilizing a new pain management template in the medical record keeping system.

67. On or about December 22, 2017, Patient B presented to Respondent for a refill on her medications. Respondent documented that she was a "pleasant female who walks in with a antalgic crippled gait." Despite the notes in the history of present illness, in the physical examination, Respondent described Patient B as having a normal gait, with full range of motion.

68. In 2017, Patient B presented to Respondent's clinic for treatment approximately 16 times, meeting with Respondent each time.

69. During the period of on or about January 9, 2017 through December 22, 2017, Patient B filled the following prescriptions for controlled substances:

Date Filled	Drug Name	Form	Drug Strength	Qty	Days' Supply	Prescriber Name
1/9/2017	HYDROCODONE BITARTRATE-ACETAMINOPHEN	TAB	325 MG-10 MG	90	15	Respondent
1/27/2017	HYDROCODONE BITARTRATE-ACETAMINOPHEN	TAB	325 MG-10 MG	90	15	Respondent
1/27/2017	ZOLPIDEM TARTRATE	TAB	10 MG	30	30	Respondent
2/10/2017	BUTALBITAL-APAP-CAFFEINE-CODEINE	CAP	325 MG-50 MG-40 MG-30 MG	18	3	G.P., P.A.
2/24/2017	HYDROCODONE BITARTRATE-ACETAMINOPHEN	TAB	325 MG-5 MG	60	15	Respondent

Date Filled	Drug Name	Form	Drug Strength	Qty	Days' Supply	Prescriber Name
2/24/2017	ZOLPIDEM TARTRATE	TAB	10 MG	30	30	Respondent
3/16/2017	HYDROCODONE BITARTRATE-ACETAMINOPHEN	TAB	325 MG-5 MG	50	12	Respondent
3/20/2017	ZOLPIDEM TARTRATE	TAB	10 MG	30	30	Respondent
4/14/2017	ACETAMINOPHEN-HYDROCODONE BITARTRATE	TAB	325 MG-5 MG	50	12	Respondent
4/14/2017	ZOLPIDEM TARTRATE	TAB	5 MG	30	30	Respondent
5/5/2017	HYDROCODONE BITARTRATE-ACETAMINOPHEN	TAB	325 MG-10 MG	90	15	Respondent
5/5/2017	ZOLPIDEM TARTRATE	TAB	10 MG	30	30	Respondent
5/18/2017	BUTRANS	TDM	5 MCG/1 HR	4	28	M.B., M.D.
6/5/2017	HYDROCODONE BITARTRATE-ACETAMINOPHEN	TAB	325 MG-5 MG	120	30	Respondent
6/5/2017	ZOLPIDEM TARTRATE	TAB	10 MG	30	30	Respondent
6/29/2017	HYDROCODONE BITARTRATE-ACETAMINOPHEN	TAB	325 MG-5 MG	120	30	Respondent
6/29/2017	ZOLPIDEM TARTRATE	TAB	10 MG	30	30	Respondent
7/18/2017	ACETAMINOPHEN-CODEINE PHOSPHATE	TAB	300 MG-30 MG	50	12	Respondent
7/18/2017	ZOLPIDEM TARTRATE	TAB	10 MG	60	60	Respondent
7/28/2017	HYDROCODONE BITARTRATE-ACETAMINOPHEN	TAB	325 MG-10 MG	60	20	Respondent
8/15/2017	HYDROCODONE BITARTRATE-ACETAMINOPHEN	TAB	325 MG-10 MG	60	10	Respondent
8/15/2017	ZOLPIDEM TARTRATE	TAB	10 MG	30	30	Respondent
9/5/2017	HYDROCODONE BITARTRATE-ACETAMINOPHEN	TAB	325 MG-10 MG	120	20	Respondent
9/8/2017	ZOLPIDEM TARTRATE	TAB	10 MG	30	30	Respondent
9/29/2017	HYDROCODONE BITARTRATE-ACETAMINOPHEN	TAB	325 MG-10 MG	120	20	Respondent
10/2/2017	ZOLPIDEM TARTRATE	TAB	10 MG	30	30	Respondent
10/24/2017	HYDROCODONE BITARTRATE-ACETAMINOPHEN	TAB	325 MG-5 MG	50	12	Respondent
10/26/2017	ZOLPIDEM TARTRATE	TAB	10 MG	30	30	Respondent
11/7/2017	HYDROCODONE BITARTRATE-ACETAMINOPHEN	TAB	325 MG-5 MG	50	12	Respondent
11/27/2017	HYDROCODONE BITARTRATE-ACETAMINOPHEN	TAB	325 MG-10 MG	120	20	Respondent
11/27/2017	ZOLPIDEM TARTRATE	TAB	10 MG	30	30	Respondent
12/22/2017	HYDROCODONE BITARTRATE-ACETAMINOPHEN	TAB	325 MG-10 MG	120	20	Respondent

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2018

70. On or about March 26, 2018, Patient B presented to Respondent for a thyroid mass biopsy and a referral to a neurologist for chronic headaches, complaining of a chronic cough or chest pain, shortness of breath, and medication refills. Patient B stated that she had lost all of her medications at the emergency room , and needed early refills. Respondent stated that he provided the refill because he "could not disprove...she lost it." Respondent documented in the assessment/plan that her urine toxicology was normal and her "contract is signed," but no pain contract or toxicology testing is documented in Patient B's medical records.

71. In 2018, Patient B presented to Respondent's clinic for treatment approximately 21 times, meeting with Respondent approximately 20 times.

72. During the period of on or about January 12, 2018 through December 4, 2018, Patient B filled the following prescriptions for controlled substances:

Date Filled	Drug Name	Form	Drug Strength	Qty	Days' Supply	Prescriber Name
1/12/2018	HYDROCODONE BITARTRATE-ACETAMINOPHEN	TAB	325 MG-10 MG	60	10	Respondent
1/12/2018	ZOLPIDEM TARTRATE	TAB	10 MG	30	30	Respondent
1/26/2018	HYDROCODONE BITARTRATE-ACETAMINOPHEN	TAB	325 MG-10 MG	60	10	Respondent
2/9/2018	HYDROCODONE BITARTRATE-ACETAMINOPHEN	TAB	325 MG-5 MG	30	7	Respondent
2/9/2018	ZOLPIDEM TARTRATE	TAB	10 MG	30	30	Respondent
2/21/2018	HYDROCODONE BITARTRATE-ACETAMINOPHEN	TAB	325 MG-5 MG	30	7	Respondent
3/5/2018	ZOLPIDEM TARTRATE	TAB	10 MG	30	30	Respondent
3/9/2018	HYDROCODONE BITARTRATE-ACETAMINOPHEN	TAB	325 MG-10 MG	60	10	Respondent
3/26/2018	HYDROCODONE BITARTRATE-ACETAMINOPHEN	TAB	325 MG-10 MG	60	10	Respondent
4/3/2018	ZOLPIDEM TARTRATE	TAB	10 MG	30	30	Respondent
4/10/2018	HYDROCODONE BITARTRATE-ACETAMINOPHEN	TAB	325 MG-5 MG	30	7	C.M., M.D.
4/25/2018	HYDROCODONE BITARTRATE-ACETAMINOPHEN	TAB	325 MG-5 MG	50	12	Respondent
4/27/2018	ZOLPIDEM TARTRATE	TAB	10 MG	30	30	Respondent
5/21/2018	HYDROCODONE BITARTRATE-ACETAMINOPHEN	TAB	325 MG-5 MG	50	12	Respondent

Date Filled	Drug Name	Form	Drug Strength	Qty	Days' Supply	Prescriber Name
5/21/2018	ZOLPIDEM TARTRATE	TAB	10 MG	30	30	Respondent
6/7/2018	TEMAZEPAM	CAP	15 MG	30	30	Respondent
6/25/2018	HYDROCODONE BITARTRATE-ACETAMINOPHEN	TAB	325 MG-5 MG	90	22	Respondent
6/25/2018	ZOLPIDEM TARTRATE	TAB	10 MG	30	30	Respondent
7/18/2018	HYDROCODONE BITARTRATE-ACETAMINOPHEN	TAB	325 MG-5 MG	90	22	Respondent
7/18/2018	ZOLPIDEM TARTRATE	TAB	10 MG	30	30	Respondent
8/15/2018	ZOLPIDEM TARTRATE	TAB	10 MG	30	30	Respondent
8/17/2018	HYDROCODONE BITARTRATE-ACETAMINOPHEN	TAB	325 MG-5 MG	60	15	Respondent
9/7/2018	HYDROCODONE BITARTRATE-ACETAMINOPHEN	TAB	325 MG-5 MG	60	15	Respondent
9/10/2018	ZOLPIDEM TARTRATE	TAB	10 MG	30	30	Respondent
10/3/2018	ZOLPIDEM TARTRATE	TAB	5 MG	30	30	Respondent
10/11/2018	HYDROCODONE BITARTRATE-ACETAMINOPHEN	TAB	325 MG-5 MG	28	7	S.B., M.D.
11/2/2018	ZOLPIDEM TARTRATE	TAB	10 MG	30	30	Respondent
11/14/2018	HYDROCODONE BITARTRATE-ACETAMINOPHEN	TAB	325 MG-5 MG	60	15	Respondent
12/4/2018	BUTALBITAL-ACETAMINOPHEN-CAFFEINE	TAB	325 MG-50 MG-40 MG	7	2	M.G.
12/4/2018	HYDROCODONE BITARTRATE-ACETAMINOPHEN	TAB	325 MG-5 MG	60	15	Respondent
12/4/2018	ZOLPIDEM TARTRATE	TAB	10 MG	30	30	Respondent

Departures: Patient B

73. Respondent's medical records for Patient B consist of templated forms, with significant discrepancies between the information documented in the history of presenting illness, and the physical examination. Respondent frequently included repeated identical findings at each visit, and failed to record evidence in physical examinations to substantiate the diagnoses for Patient B. Respondent's failure to adequately and accurately document the physical examination at each visit for Patient B constituted a separate and distinct departure from the standard of care.

Patient C

2016

74. On or about January 20, 2016, Patient C presented to Respondent seeking refills of his medications. Respondent documented that a pain contract was signed, and a drug screen was

performed. Respondent refilled his medications, and recommended a follow up appointment in four weeks.

75. On or about February 26, 2016, Patient C completed a toxicology test that was positive for benzodiazepines and cannabinoids.

76. On or about April 25, 2016, Patient C completed a toxicology test that was positive for cannabinoids, but negative for benzodiazepines.

77. On or about June 3, 2016, Patient C presented to Respondent, complaining of low back pain with numbness down his right leg. Despite Patient C's compliant of numbness, Respondent documented a normal musculoskeletal examination. Respondent stated that he was not the treating provider for Patient C's chronic lower back pain, but he did document subjective complaints of leg numbness and weakness.

78. On or about June 27, 2016, Patient C presented to Respondent complaining of numbness down his right leg, and seeking refills of his medications. Respondent documented a normal musculoskeletal examination, despite Patient C's pain and complaint of right leg numbness.

79. On or about August 12, 2016, Patient C presented to Respondent for refills of his medications. In the review of systems section of the medical records related to the musculoskeletal system, Respondent wrote "Negative except as noted in HPI." In the physical examination of the medical records related to the musculoskeletal system, Respondent wrote, "No joint deformity, erythema, or tenderness. Full ROM all joints. Normal gait." Respondent repeated these entries without change at almost every one of Patient C's visits, no matter what changes were reported by the patient.

80. In 2016, Patient C presented to Respondent's clinic for treatment approximately 14 times, meeting with Respondent each time.

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81. During the period of on or about June 27, 2016 through December 16, 2016, Patient C filled the following prescriptions for controlled substances:

Date Filled	Drug Name	Form	Drug Strength	Qty	Days' Supply	Prescriber Name
6/27/2016	LORAZEPAM	TAB	0.5 MG	30	10	Respondent
6/27/2016	TRAMADOL HCL	TAB	50 MG	90	15	Respondent
7/19/2016	TRAMADOL HCL	TAB	50 MG	90	15	Respondent
8/12/2016	ALPRAZOLAM	TAB	0.25 MG	90	30	Respondent
8/12/2016	TRAMADOL HCL	TAB	50 MG	90	15	Respondent
9/2/2016	TRAMADOL HCL	TAB	50 MG	90	15	Respondent
9/6/2016	ALPRAZOLAM	TAB	0.25 MG	60	20	Respondent
9/20/2016	TRAMADOL HCL	TAB	50 MG	60	10	Respondent
10/4/2016	TRAMADOL HCL	TAB	50 MG	90	15	Respondent
10/25/2016	ALPRAZOLAM	TAB	0.5 MG	50	16	Respondent
10/25/2016	TRAMADOL HCL	TAB	50 MG	90	15	Respondent
11/18/2016	ALPRAZOLAM	TAB	0.5 MG	60	20	Respondent
11/18/2016	TRAMADOL HCL	TAB	50 MG	90	15	Respondent
12/16/2016	ALPRAZOLAM	TAB	0.5 MG	60	20	Respondent
12/16/2016	TRAMADOL HCL	TAB	50 MG	180	15	Respondent

2017

82. On or about March 13, 2017, Patient C completed a toxicology test that was positive for benzodiazepines, opiates, and cannabinoids.

83. In 2017, Patient C presented to Respondent's clinic for treatment approximately 13 times, meeting with Respondent each time.

84. During the period of on or about January 16, 2017 through December 28, 2017, Patient C filled the following prescriptions for controlled substances:

Date Filled	Drug Name	Form	Drug Strength	Qty	Days' Supply	Prescriber Name
1/16/2017	ALPRAZOLAM	TAB	0.25 MG	60	20	Respondent
1/16/2017	TRAMADOL HCL	TAB	50 MG	180	15	Respondent
2/14/2017	ALPRAZOLAM	TAB	1 MG	90	30	Respondent
2/14/2017	TRAMADOL HCL	TAB	50 MG	180	30	Respondent
3/13/2017	TRAMADOL HCL	TAB	50 MG	180	30	Respondent
4/11/2017	ALPRAZOLAM	TAB	1 MG	90	30	Respondent
4/11/2017	TRAMADOL HCL	TAB	50 MG	180	30	Respondent

Date Filled	Drug Name	Form	Drug Strength	Qty	Days' Supply	Prescriber Name
5/12/2017	ALPRAZOLAM	TAB	2 MG	45	15	Respondent
5/12/2017	TRAMADOL HCL	TAB	50 MG	180	30	Respondent
6/7/2017	ALPRAZOLAM	TAB	2 MG	45	15	Respondent
6/7/2017	TRAMADOL HCL	TAB	50 MG	180	30	Respondent
6/28/2017	ALPRAZOLAM	TAB	2 MG	45	15	Respondent
7/5/2017	TRAMADOL HCL	TAB	50 MG	180	30	Respondent
7/25/2017	ALPRAZOLAM	TAB	2 MG	60	20	Respondent
8/2/2017	TRAMADOL HCL	TAB	50 MG	180	30	Respondent
8/22/2017	ALPRAZOLAM	TAB	2 MG	60	20	Respondent
8/28/2017	TRAMADOL HCL	TAB	50 MG	180	30	Respondent
9/22/2017	ALPRAZOLAM	TAB	1 MG	60	20	Respondent
9/22/2017	TRAMADOL HCL	TAB	50 MG	180	30	Respondent
10/9/2017	ALPRAZOLAM	TAB	1 MG	60	20	Respondent
10/27/2017	ALPRAZOLAM	TAB	2 MG	60	20	Respondent
10/31/2017	TRAMADOL HCL	TAB	50 MG	180	30	T.Y, M.D.
11/30/2017	ALPRAZOLAM	TAB	2 MG	60	20	Respondent
12/1/2017	TRAMADOL HCL	TAB	50 MG	180	30	L.Y.
12/28/2017	ALPRAZOLAM	TAB	2 MG	60	20	Respondent
12/28/2017	TRAMADOL HCL	TAB	50 MG	180	30	L.Y.

2018

85. On or about August 20, 2018, Respondent documented that he had tried fluoxetine for Patient C, and it was effective; however, Respondent stated that he did not use alternative non-controlled medications for his patients because he had tried Prozac in the past, and it did not work.

86. On or about December 28, 2018, Respondent documented that he intended to "reduce Xanax by 30% next visit," and refer Patient C to a psychologist.

87. In 2018, Patient C presented to Respondent's clinic for treatment approximately 14 times, meeting with Respondent each time.

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88. During the period of on or about January 26, 2018 through December 21, 2018, Patient C filled the following prescriptions for controlled substances:

Date Filled	Drug Name	Form	Drug Strength	Qty	Days' Supply	Prescriber Name
1/26/2018	ALPRAZOLAM	TAB	2 MG	60	20	Respondent
2/6/2018	TRAMADOL HCL	TAB	50 MG	180	30	L.Y.
2/22/2018	ALPRAZOLAM	TAB	2 MG	60	20	Respondent
3/6/2018	TRAMADOL HCL	TAB	50 MG	180	30	L.Y.
3/19/2018	ALPRAZOLAM	TAB	2 MG	60	20	Respondent
4/4/2018	TRAMADOL HCL	TAB	50 MG	180	30	L.Y.
4/19/2018	ALPRAZOLAM	TAB	2 MG	60	20	Respondent
5/8/2018	TRAMADOL HCL	TAB	50 MG	180	30	A.R., M.D.
5/14/2018	ALPRAZOLAM	TAB	2 MG	60	20	Respondent
6/8/2018	ALPRAZOLAM	TAB	2 MG	60	20	Respondent
6/13/2018	TRAMADOL HCL	TAB	50 MG	180	30	L.Y.
6/27/2018	ALPRAZOLAM	TAB	2 MG	60	20	Respondent
7/10/2018	TRAMADOL HCL	TAB	50 MG	180	30	R.T., N.P.
7/25/2018	ALPRAZOLAM	TAB	2 MG	90	30	Respondent
8/8/2018	TRAMADOL HCL	TAB	50 MG	180	30	L.Y.
8/24/2018	ALPRAZOLAM	TAB	2 MG	90	30	Respondent
9/5/2018	TRAMADOL HCL	TAB	50 MG	180	30	L.Y.
9/24/2018	ALPRAZOLAM	TAB	2 MG	90	30	Respondent
10/22/2018	TRAMADOL HCL	TAB	50 MG	180	30	T.M.
10/23/2018	ALPRAZOLAM	TAB	2 MG	90	30	Respondent
11/19/2018	TRAMADOL HCL	TAB	50 MG	180	30	T.M.
11/20/2018	ALPRAZOLAM	TAB	2 MG	90	30	Respondent
12/17/2018	TRAMADOL HCL	TAB	50 MG	180	30	T.M.
12/21/2018	ALPRAZOLAM	TAB	2 MG	60	20	Respondent

2019

89. On or about January 19, 2019, Respondent documented that Patient C participated in a toxicology screen which was negative for amphetamines, but positive for cannabis. On or about February 18, 2019, Respondent attempted to taper Patient C off of alprazolam.

90. On or about February 18, 2019, Patient C presented to Respondent for refills. Patient C participated in a drug toxicology test prior to this visit, which was only positive for marijuana. Patient C reported that he was unable to keep his appointment with his psychologist. Respondent believed it was possible that Patient C was taking the medications as needed, and could have had

a negative drug screen. Respondent stated that he told Patient C that he must regularly see a psychologist in order to continue to receive prescriptions of alprazolam. Despite Patient C's inconsistent visits to the psychologist, Respondent continued to prescribe alprazolam.

91. During the period of on or about January 1, 2019 through February 18, 2019, Patient C presented to Respondent's clinic for treatment approximately 14 times, meeting with Respondent each time.

92. During the period of on or about January 15, 2019 through June 11, 2019, Patient C filled the following prescriptions for controlled substances:

Date Filled	Drug Name	Form	Drug Strength	Qty	Days' Supply	Prescriber Name
1/15/2019	TRAMADOL HCL	TAB	50 MG	180	30	T.M.
1/18/2019	ALPRAZOLAM	TAB	1 MG	60	20	Respondent
2/4/2019	ALPRAZOLAM	TAB	1 MG	30	10	Respondent
2/8/2019	TRAMADOL HCL	TAB	50 MG	180	30	T.M.
2/19/2019	ALPRAZOLAM	TAB	1 MG	90	30	Respondent
3/19/2019	ALPRAZOLAM	TAB	1 MG	24	8	Respondent
3/27/2019	ALPRAZOLAM	TAB	1 MG	62	21	Respondent
4/19/2019	ALPRAZOLAM	TAB	1 MG	62	20	Respondent
5/17/2019	ALPRAZOLAM	TAB	1 MG	62	20	Respondent
6/11/2019	ALPRAZOLAM	TAB	1 MG	62	20	Respondent

Departures: Patient C

93. Respondent's medical records for Patient C consist of templated forms, with significant discrepancies between the information documented in the history of presenting illness, and the physical examination. Respondent frequently included repeated identical findings at each visit, and failed to record evidence in physical examinations to substantiate the diagnoses for Patient C. Respondent's failure to adequately and accurately document the physical examination at each visit for Patient C constituted a separate and distinct departure from the standard of care.

94. Respondent failed to employ a step-wise approach to treating Patient C's anxiety. Respondent continued to prescribe short acting benzodiazepines, absent documentation of an adequate justification to support the prescriptions. Respondent did not document consideration or use of long acting benzodiazepines rather than short acting benzodiazepines in the care of Patient C. Respondent did not document consideration or use of non-controlled substances in the

treatment of Patient C's anxiety. Respondent's use of benzodiazepines in the treatment of Patient C constituted a simple departure from the standard of care, and demonstrated a lack of knowledge.

Patient D

2017

95. On or about February 23, 2017, Patient D presented to Respondent for treatment at 37 years old seeking refills of his medications. Respondent diagnosed Patient D with a chronic cough, low back pain, prediabetes, hypertension and chronic gastroesophageal reflux disease. Respondent prescribed hydrocodone, carisoprodol, promethazine with codeine cough syrup, gabapentin, ibuprofen, losartan and omeprazole. Respondent continued to prescribe Patient D promethazine with codeine regularly for another six months. Patient D's wife, Patient E, was also concurrently receiving treatment from Respondent. Respondent prescribed Patient D and Patient E concurrent prescriptions for promethazine with codeine, hydrocodone, and carisoprodol. Respondent stated that he believed that at one point they were sharing their controlled substances, but did nothing to alter their identical prescribing patterns until August 21, 2017, when he ordered an MRI and a urine drug screen. Respondent believed Patient D was abusing his drugs, and when asked, stated that "I didn't do anything about it. My – my – my mistake." In an interview with the Board's investigators, Respondent stated that Patient D sought treatment from multiple providers in order to obtain opioid medications, eventually resulting in his dismissal from the practice.

96. In 2017, Patient D presented to Respondent's clinic for treatment approximately 14 times, meeting with Respondent each time.

97. During the period of on or about January 17, 2017 through November 28, 2017, Patient D filled the following prescriptions for controlled substances:

Date Filled	Drug Name	Form	Drug Strength	Qty	Days' Supply	Prescriber Name
1/17/2017	CARISOPRODOL	TAB	350 MG	90	30	A.G.
1/21/2017	HYDROCODONE BITARTRATE-ACETAMINOPHE	TAB	325 MG-10 MG	60	15	C.O., N.P.
1/23/2017	PROMETHAZINE HCL-CODEINE PHOSPHATE	SYR	6.25MG/5ML-10MG/5ML	120	6	A.G.

Date Filled	Drug Name	Form	Drug Strength	Qty	Days' Supply	Prescriber Name
2/21/2017	CARISOPRODOL	TAB	350 MG	90	30	A.G.
2/23/2017	HYDROCODONE BITARTRATE-ACETAMINOPHE	TAB	325 MG-5 MG	60	30	Respondent
2/23/2017	PROMETHAZINE HCL-CODEINE PHOSPHATE	SYR	6.25MG/5ML-10MG/5ML	120	6	Respondent
2/27/2017	HYDROCODONE BITARTRATE-ACETAMINOPHE	TAB	325 MG-10 MG	60	15	R.E.
3/16/2017	PROMETHAZINE HCL-CODEINE PHOSPHATE	SYR	6.25MG/5ML-10MG/5ML	240	12	R.A., M.D.
3/18/2017	CARISOPRODOL	TAB	350 MG	90	30	Respondent
3/20/2017	HYDROCODONE BITARTRATE-ACETAMINOPHE	TAB	325 MG-5 MG	60	30	R.A., M.D.
3/30/2017	PROMETHAZINE HCL-CODEINE PHOSPHATE	SYR	6.25MG/5ML-10MG/5ML	240	12	R.A., M.D.
4/13/2017	CARISOPRODOL	TAB	350 MG	90	30	Respondent
4/14/2017	HYDROCODONE BITARTRATE-ACETAMINOPHE	TAB	325 MG-5 MG	60	30	R.A., M.D.
4/24/2017	HYDROCODONE BITARTRATE-ACETAMINOPHE	TAB	325 MG-10 MG	60	15	C.O., N.P.
4/26/2017	PROMETHAZINE HCL-CODEINE PHOSPHATE	SYR	6.25MG/5ML-10MG/5ML	240	12	Respondent
5/8/2017	CARISOPRODOL	TAB	350 MG	90	30	Respondent
5/9/2017	HYDROCODONE BITARTRATE-ACETAMINOPHE	TAB	325 MG-5 MG	60	30	Respondent
5/9/2017	PROMETHAZINE HCL-CODEINE PHOSPHATE	SYR	6.25MG/5ML-10MG/5ML	240	12	Respondent
5/25/2017	PROMETHAZINE HCL-CODEINE PHOSPHATE	SYR	6.25MG/5ML-10MG/5ML	240	12	Respondent
6/3/2017	CARISOPRODOL	TAB	350 MG	90	30	Respondent
6/3/2017	HYDROCODONE BITARTRATE-ACETAMINOPHE	TAB	325 MG-5 MG	60	30	Respondent
6/8/2017	PROMETHAZINE HCL-CODEINE PHOSPHATE	SYR	6.25MG/5ML-10MG/5ML	240	12	Respondent
6/21/2017	HYDROCODONE BITARTRATE-ACETAMINOPHE	TAB	325 MG-10 MG	60	15	H.M.
7/7/2017	CARISOPRODOL	TAB	350 MG	42	14	Respondent
7/7/2017	HYDROCODONE BITARTRATE-ACETAMINOPHE	TAB	325 MG-5 MG	60	30	Respondent
7/7/2017	PROMETHAZINE HCL-CODEINE PHOSPHATE	SYR	6.25MG/5ML-10MG/5ML	240	12	Respondent
7/19/2017	PROMETHAZINE HCL-CODEINE PHOSPHATE	SYR	6.25MG/5ML-10MG/5ML	240	12	Respondent
7/21/2017	CARISOPRODOL	TAB	350 MG	90	30	Respondent
8/7/2017	HYDROCODONE BITARTRATE-ACETAMINOPHE	TAB	325 MG-5 MG	60	30	Respondent
8/21/2017	CARISOPRODOL	TAB	350 MG	90	30	Respondent

Date Filled	Drug Name	Form	Drug Strength	Qty	Days' Supply	Prescriber Name
9/19/2017	CARISOPRODOL	TAB	350 MG	90	30	Respondent
9/19/2017	HYDROCODONE BITARTRATE-ACETAMINOPHE	TAB	325 MG-5 MG	60	30	Respondent
10/10/2017	HYDROCODONE BITARTRATE-ACETAMINOPHE	TAB	325 MG-10 MG	60	15	Respondent
10/16/2017	CARISOPRODOL	TAB	350 MG	90	30	Respondent
10/24/2017	HYDROCODONE BITARTRATE-ACETAMINOPHE	TAB	325 MG-5 MG	60	30	Respondent
11/28/2017	HYDROCODONE BITARTRATE-ACETAMINOPHE	TAB	325 MG-5 MG	60	30	Respondent

Departures: Patient D

98. Respondent did not adequately document the characterization Patient D's pain including etiology, location, radiation, intensity, relieving and aggravating factors, and impact on his quality of life. Respondent's medical records for Patient D consist of templated forms, with significant discrepancies between the information documented in the history of presenting illness, and the physical examination. Respondent frequently included repeated identical findings at each visit, and failed to record evidence in physical examinations to substantiate the diagnoses for Patient D's chronic pain and chronic cough. Respondent's failure to adequately and accurately document the physical examination at each visit for Patient D constituted a separate and distinct departure from the standard of care.

99. Respondent prescribed Patient D a combination of opioids in combinations with carisoprodol, which carries a risk of respiratory depression, overdose and death. Respondent did not adequately assess the benefits, harms, pain and functional improvements, consideration of alternative non-opioid modalities, utilization of urine drugs screens or review of CURES reports while prescribing controlled substances to Patient D. Respondent continued to prescribe the same controlled substances medications to Patient D, despite his concern that the medication was being abused by Patient D and/or his spouse. Respondent's prescribing of controlled substances to Patient D constitutes a departure from the standard of care, and demonstrates a lack of knowledge.

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Patient E

2016

100. On or about November 3, 2016, Patient E presented to Respondent seeking refills of her medications, and complaining of continued right ear pain. Respondent's records note that her history includes diabetes, bipolar personality, and chronic low back pain. Respondent prescribed hydrocodone, carisoprodol, alprazolam, and promethazine with codeine concurrently from approximately November 7, 2016 through August 5, 2017. Respondent did not document any discussion with Patient E regarding the dangers of respiratory depression while taking a combination of opiates and benzodiazepines. Respondent was concurrently prescribing the same medications to Patient E's husband, Patient D. Respondent did not document any objective findings to substantiate his diagnosis of chronic back pain. Respondent stated that his long term treatment plan for Patient E was to refer her to a pain management specialist, and "to catch her in her lies...with the drug screen."

101. On or about December 1, 2016, Patient E presented to Respondent for refills of her medications. Respondent wrote in the history of presenting illness that Patient E "has polycystic ovaries and is having heavy periods since October...her pain hematocrit is 15.1," but Respondent did not include anemia on Patient E's problem list.

102. In 2016, Patient E presented to Respondent's clinic for treatment approximately 3 times, meeting with Respondent each time.

103. During the period of on or about June 28, 2016 through December 27, 2016, Patient E filled the following prescriptions for controlled substances:

Date Filled	Drug Name	Form	Drug Strength	Qty	Days' Supply	Prescriber Name
6/28/2016	PROMETHAZINE HCL-CODEINE PHOSPHATE	SYR	6.25MG/5ML-10MG/5ML	240	16	A.G.
7/8/2016	CARISOPRODOL	TAB	350 MG	60	30	A.G.
7/11/2016	HYDROCODONE BITARTRATE-ACETAMINOPHEN	TAB	325 MG-10 MG	60	30	A.G.
7/18/2016	PROMETHAZINE HCL-CODEINE PHOSPHATE	SYR	6.25MG/5ML-10MG/5ML	240	16	A.G.
8/3/2016	CARISOPRODOL	TAB	350 MG	60	30	A.G.

Date Filled	Drug Name	Form	Drug Strength	Qty	Days' Supply	Prescriber Name
8/10/2016	HYDROCODONE BITARTRATE-ACETAMINOPHEN	TAB	325 MG-10 MG	60	30	A.G.
8/10/2016	PROMETHAZINE HCL-CODEINE PHOSPHATE	SYR	6.25MG/5ML-10MG/5ML	240	16	A.G.
9/6/2016	CARISOPRODOL	TAB	350 MG	60	30	A.G.
9/6/2016	HYDROCODONE BITARTRATE-ACETAMINOPHEN	TAB	325 MG-10 MG	60	30	A.G.
10/3/2016	CARISOPRODOL	TAB	350 MG	60	30	A.G.
10/3/2016	HYDROCODONE BITARTRATE-ACETAMINOPHEN	TAB	325 MG-10 MG	60	30	A.G.
11/7/2016	ALPRAZOLAM	TAB	1 MG	60	20	Respondent
11/7/2016	CARISOPRODOL	TAB	350 MG	60	30	Respondent
11/7/2016	HYDROCODONE BITARTRATE-ACETAMINOPHEN	TAB	325 MG-10 MG	60	30	Respondent
12/2/2016	CARISOPRODOL	TAB	350 MG	60	30	Respondent
12/2/2016	HYDROCODONE BITARTRATE-ACETAMINOPHEN	TAB	325 MG-10 MG	60	30	Respondent
12/13/2016	ALPRAZOLAM	TAB	1 MG	60	20	Respondent
12/27/2016	CARISOPRODOL	TAB	350 MG	60	30	Respondent

2017

104. On or about March 16, 2017, Patient E presented to Respondent for refills and draining of an axillary abscess. Respondent included the abscess in the history of presenting illness, but did not document the abscess in the physical examination.

105. On or about March 29, 2017, Patient E presented to Respondent for refills on her medications, and complaining of a cough, sinus congestion, and earaches lasting five days. Respondent documented a normal physical examination, but diagnosed Patient E with acute pharyngitis, and prescribed her an antibiotic.

106. On or about March 30, 2017, Patient E returned to Respondent complaining of three episodes of watery diarrhéa per day. Respondent stated that he considered a clostridium difficile infection, but failed to document it in his differential diagnosis.

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107. On or about May 18, 2017, Patient E presented to Respondent with an abscess of her right groin area. Respondent documented a normal physical examination, that did not mention the right groin abscess. Respondent believed Patient E was diverting or abusing her controlled substances, because they should have been positive on the toxicology test. Respondent ordered a repeat of the test before the next visit, and noted that if it was negative she would be discharged.

108. On or about July 28, 2017, Patient E presented to Respondent for a medication reconciliation appointment. Respondent noted that Patient E had been "getting too many narcotics," and ordered another drug toxicology test. The following day, Patient E completed a drug toxicology screen that was negative for all drugs tested.

109. On or about July 29, 2017, Respondent added an addendum to Patient E's medical record that stated, "[d]rug screen negative no more anxiolytics or Norco." Despite this entry, Patient E continued to refill hydrocodone and alprazolam prescriptions from Respondent in November 2017, and January 2018.

110. In 2017, Patient E presented to Respondent's clinic for treatment approximately 28 times, meeting with Respondent each time.

111. During the period of on or about January 5, 2017 through November 28, 2017, Patient E filled the following prescriptions for controlled substances:

Date Filled	Drug Name	Form	Drug Strength	Qty	Days' Supply	Prescriber Name
1/5/2017	HYDROCODONE BITARTRATE-ACETAMINOPHEN	TAB	325 MG-10 MG	60	30	Respondent
1/5/2017	PROMETHAZINE HCL-CODEINE PHOSPHATE	SYR	6.25MG/5ML-10MG/5ML	240	12	Respondent
1/26/2017	ALPRAZOLAM	TAB	2 MG	50	16	Respondent
1/26/2017	PROMETHAZINE HCL-CODEINE PHOSPHATE	SYR	6.25MG/5ML-10MG/5ML	240	12	Respondent
1/30/2017	CARISOPRODOL	TAB	350 MG	60	30	Respondent
2/2/2017	HYDROCODONE BITARTRATE-ACETAMINOPHEN	TAB	325 MG-10 MG	60	30	Respondent
2/9/2017	ALPRAZOLAM	TAB	2 MG	50	16	Respondent
2/9/2017	PROMETHAZINE HCL-CODEINE PHOSPHATE	SYR	6.25MG/5ML-10MG/5ML	240	12	Respondent

Date Filled	Drug Name	Form	Drug Strength	Qty	Days' Supply	Prescriber Name
2/23/2017	ALPRAZOLAM	TAB	2 MG	60	20	Respondent
2/23/2017	PROMETHAZINE HCL-CODEINE PHOSPHATE	SYR	6.25MG/5ML-10MG/5ML	240	12	Respondent
2/24/2017	CARISOPRODOL	TAB	350 MG	60	30	Respondent
2/27/2017	HYDROCODONE BITARTRATE-ACETAMINOPHEN	TAB	325 MG-10 MG	60	30	Respondent
3/9/2017	PROMETHAZINE HCL-CODEINE PHOSPHATE	SYR	6.25MG/5ML-10MG/5ML	240	12	Respondent
3/20/2017	CARISOPRODOL	TAB	350 MG	60	30	Respondent
3/24/2017	ALPRAZOLAM	TAB	2 MG	60	20	Respondent
3/24/2017	HYDROCODONE BITARTRATE-ACETAMINOPHEN	TAB	325 MG-10 MG	60	30	Respondent
3/24/2017	PROMETHAZINE HCL-CODEINE PHOSPHATE	SYR	6.25MG/5ML-10MG/5ML	240	12	Respondent
3/30/2017	DIPHENOXYLATE HCL-ATROPINE SULFATE	TAB	0.025 MG-2.5 MG	10	2	Respondent
4/3/2017	PROMETHAZINE HCL-CODEINE PHOSPHATE	SYR	6.25MG/5ML-10MG/5ML	240	12	Respondent
4/11/2017	DIPHENOXYLATE HCL-ATROPINE SULFATE	TAB	0.025 MG-2.5 MG	10	2	Respondent
4/13/2017	ALPRAZOLAM	TAB	2 MG	60	20	Respondent
4/13/2017	PROMETHAZINE HCL-CODEINE PHOSPHATE	SYR	6.25MG/5ML-10MG/5ML	240	12	Respondent
4/17/2017	CARISOPRODOL	TAB	350 MG	60	30	Respondent
4/18/2017	HYDROCODONE BITARTRATE-ACETAMINOPHEN	TAB	325 MG-10 MG	60	30	Respondent
4/26/2017	PROMETHAZINE HCL-CODEINE PHOSPHATE	SYR	6.25MG/5ML-10MG/5ML	240	12	Respondent
5/4/2017	ALPRAZOLAM	TAB	2 MG	60	20	Respondent
5/6/2017	PROMETHAZINE HCL-CODEINE PHOSPHATE	SYR	6.25MG/5ML-10MG/5ML	240	12	Respondent
5/12/2017	CARISOPRODOL	TAB	350 MG	60	30	Respondent
5/13/2017	HYDROCODONE BITARTRATE-ACETAMINOPHEN	TAB	325 MG-10 MG	60	30	Respondent
5/16/2017	ZOLPIDEM TARTRATE	TAB	10 MG	30	30	A.G.
5/18/2017	PROMETHAZINE HCL-CODEINE PHOSPHATE	SYR	6.25MG/5ML-10MG/5ML	240	12	Respondent
5/30/2017	ALPRAZOLAM	TAB	2 MG	60	20	Respondent
5/30/2017	PROMETHAZINE HCL-CODEINE PHOSPHATE	SYR	6.25MG/5ML-10MG/5ML	240	12	Respondent
5/31/2017	CARISOPRODOL	TAB	350 MG	60	30	Respondent

Date Filled	Drug Name	Form	Drug Strength	Qty	Days' Supply	Prescriber Name
5/31/2017	HYDROCODONE BITARTRATE-ACETAMINOPHEN	TAB	325 MG-10 MG	60	30	Respondent
5/31/2017	ZOLPIDEM TARTRATE	TAB	10 MG	30	30	Respondent
6/15/2017	PROMETHAZINE HCL-CODEINE PHOSPHATE	SYR	6.25MG/5ML-10MG/5ML	240	12	Respondent
7/7/2017	HYDROCODONE BITARTRATE-ACETAMINOPHEN	TAB	325 MG-10 MG	60	30	Respondent
7/7/2017	PROMETHAZINE HCL-CODEINE PHOSPHATE	SYR	6.25MG/5ML-10MG/5ML	240	12	Respondent
7/10/2017	ALPRAZOLAM	TAB	2 MG	60	20	Respondent
7/10/2017	CARISOPRODOL	TAB	350 MG	42	14	Respondent
7/19/2017	PROMETHAZINE HCL-CODEINE PHOSPHATE	SYR	6.25MG/5ML-10MG/5ML	240	12	Respondent
7/28/2017	CARISOPRODOL	TAB	350 MG	60	20	Respondent
8/5/2017	ACETAMINOPHEN-HYDROCODONE BITARTRATE	TAB	325 MG-10 MG	60	30	Respondent
8/30/2017	ALPRAZOLAM	TAB	2 MG	60	30	A.G.
10/10/2017	ALPRAZOLAM	TAB	2 MG	60	30	A.G.
11/28/2017	ALPRAZOLAM	TAB	2 MG	60	30	Respondent

2018

112. During the period of on or about January 2, 2018 through December 21, 2018, Patient E filled the following prescriptions for controlled substances:

Date Filled	Drug Name	Form	Drug Strength	Qty	Days' Supply	Prescriber Name
1/2/2018	ALPRAZOLAM	TAB	2 MG	60	30	Respondent
2/1/2018	ALPRAZOLAM	TAB	2 MG	60	30	A.G.
3/1/2018	ALPRAZOLAM	TAB	2 MG	60	30	A.G.
3/29/2018	ALPRAZOLAM	TAB	2 MG	60	30	A.G.
4/26/2018	ALPRAZOLAM	TAB	2 MG	60	30	A.G.
5/25/2018	ALPRAZOLAM	TAB	2 MG	60	30	A.G.
6/21/2018	ALPRAZOLAM	TAB	2 MG	60	30	A.G.
7/19/2018	ALPRAZOLAM	TAB	2 MG	60	30	A.G.
8/17/2018	ALPRAZOLAM	TAB	2 MG	60	30	A.G.
9/15/2018	ALPRAZOLAM	TAB	2 MG	60	30	A.G.
10/14/2018	ALPRAZOLAM	TAB	2 MG	60	30	A.G.
11/21/2018	ALPRAZOLAM	TAB	2 MG	60	30	A.G.

Date Filled	Drug Name	Form	Drug Strength	Qty	Days' Supply	Prescriber Name
11/27/2018	HYDROCODONE BITARTRATE-ACETAMINOPHEN	TAB	325 MG-10 MG	30	30	A.G.
12/21/2018	ALPRAZOLAM	TAB	2 MG	45	30	A.G.

Patient E: Departures

113. Respondent did not document follow-up with Patient E regarding abnormal toxicology tests, which indicated that she was possibly diverting or abusing her controlled substances. Respondent did not adequately document the characterization Patient E's pain including etiology, location, radiation, intensity, relieving and aggravating factors, and impact on his quality of life. Respondent's medical records for Patient E consist of templated forms, with significant discrepancies between the information documented in the history of presenting illness, and the physical examination. Respondent frequently included repeated identical findings at each visit, and failed to record evidence in physical examinations to substantiate the diagnoses for Patient E's chronic pain and anxiety. Respondent's failure to adequately and accurately document the physical examination at each visit for Patient E constituted a separate and distinct departure from the standard of care.

114. Respondent prescribed Patient E a combination of opioids in combinations with carisoprodol, which carries a risk of respiratory depression, overdose and death. Respondent did not adequately assess the benefits, harms, pain and functional improvements, consideration of alternative non-opioid modalities, utilization of urine drugs screens or review of CURES reports while prescribing controlled substances to Patient E. Respondent continued to prescribe the same controlled substances medications to Patient E, despite his concern that the medication was being abused by Patient E and/or her spouse, Patient D. Respondent's prescribing of controlled substances to Patient E constitutes a departure from the standard of care, and demonstrates a lack of knowledge.

115. Respondent did not utilize a step wise approach in the treatment and prescribing related to Patient E's anxiety. Patient E was already taking benzodiazepines from another provider when she presented to Respondent, who elected to continue the prescriptions.

Respondent did not document the justification for continuing the benzodiazepine prescriptions. Respondent did not document any consideration of using long acting rather than short acting benzodiazepines for Patient E, which typically have less potential for addiction. Respondent did not document any consideration or attempt at treating Patient E's anxiety with non-controlled medications. Respondent's use of benzodiazepines in the treatment of Patient E's anxiety constituted a departure from the standard of care, and demonstrated a lack of knowledge.

Patient F

2017

116. On or about April 12, 2017, Patient F presented to Respondent for medication refills. Respondent noted that her chronic hip and back pain is controlled with Norco, but that she "walks with a cane and very low lordotic position and a severe antalgic gait." In the same visit, Respondent documented a normal musculoskeletal examination with full range of motion, and normal gait.

117. On or about August 18, 2017, Patient F presented to Respondent with chronic pain seeking refills of her medications. Respondent wrote "walks with a cane antalgic gate" and that she needed a refill of her Norco. Despite Respondent's documentation of the Patient's need for a cane, in the physical examination Respondent noted that she had full range of motion in all joints, and a normal gait.

118. On or about November 20, 2017, Respondent began utilizing a new template related to the opiate prescribing for Patient F. Respondent continued to repeat nearly verbatim the same assessment/plan for Patient F related to chronic pain at each following visit, without making changes that reflected the patient's change in condition. Respondent wrote that Patient F had pain from antalgia, walks with a cane, and that her Norco was not controlling her pain. Despite Respondent's documentation of the Patient's need for a cane, in the physical examination Respondent noted that she had full range of motion in all joints, and a normal gait. Respondent documented that she was suffering from chronic low back pain at a level of 9/10, using a cane in the office, but documented a physical examination with a full range of motion and normal gait.

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119. In 2017, Patient F presented to Respondent's clinic for treatment approximately 20 times, meeting with Respondent each time.

120. During the period of on or about January 9, 2017 through December 19, 2017, Patient F filled the following prescriptions for controlled substances:

Date Filled	Drug Name	Form	Drug Strength	Qty	Days' Supply	Prescriber Name
1/9/2017	CLONAZEPAM	TAB	0.5 MG	90	30	Respondent
1/9/2017	HYDROCODONE BITARTRATE-ACETAMINOPHEN	TAB	325 MG-5 MG	90	22	Respondent
2/10/2017	HYDROCODONE BITARTRATE-ACETAMINOPHEN	TAB	325 MG-5 MG	90	22	Respondent
3/7/2017	CLONAZEPAM	TAB	1 MG	90	30	Respondent
3/13/2017	HYDROCODONE BITARTRATE-ACETAMINOPHEN	TAB	325 MG-5 MG	90	22	Respondent
4/12/2017	ALPRAZOLAM	TAB	1 MG	90	30	Respondent
4/12/2017	HYDROCODONE BITARTRATE-ACETAMINOPHEN	TAB	325 MG-5 MG	90	22	Respondent
5/12/2017	ALPRAZOLAM	TAB	1 MG	90	30	Respondent
5/12/2017	HYDROCODONE BITARTRATE-ACETAMINOPHEN	TAB	325 MG-10 MG	90	15	Respondent
6/20/2017	ALPRAZOLAM	TAB	1 MG	90	30	Respondent
6/20/2017	HYDROCODONE BITARTRATE-ACETAMINOPHEN	TAB	325 MG-5 MG	90	22	Respondent
7/18/2017	ALPRAZOLAM	TAB	1 MG	90	30	Respondent
7/18/2017	HYDROCODONE BITARTRATE-ACETAMINOPHEN	TAB	325 MG-5 MG	90	22	Respondent
8/18/2017	ALPRAZOLAM	TAB	1 MG	90	30	Respondent
8/18/2017	HYDROCODONE BITARTRATE-ACETAMINOPHEN	TAB	325 MG-10 MG	120	20	Respondent
9/18/2017	ALPRAZOLAM	TAB	1 MG	60	20	Respondent
9/18/2017	HYDROCODONE BITARTRATE-ACETAMINOPHEN	TAB	325 MG-10 MG	120	20	Respondent
10/18/2017	ALPRAZOLAM	TAB	1 MG	60	20	Respondent
10/18/2017	HYDROCODONE BITARTRATE-ACETAMINOPHEN	TAB	325 MG-10 MG	120	20	Respondent
11/14/2017	ALPRAZOLAM	TAB	0.5 MG	90	30	Respondent
11/14/2017	HYDROCODONE BITARTRATE-ACETAMINOPHEN	TAB	325 MG-10 MG	120	20	Respondent
11/21/2017	ALPRAZOLAM	TAB	1 MG	50	16	Respondent
12/19/2017	ALPRAZOLAM	TAB	1 MG	60	30	Respondent
12/19/2017	HYDROCODONE BITARTRATE-ACETAMINOPHEN	TAB	325 MG-10 MG	120	20	Respondent

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2018

121. On or about December 11, 2018, Patient F presented with complaints of low back pain. Respondent wrote that her back pain was rated a level of 7/10, and that "she walks with a walker" or cane. In the same visit, Respondent documented a normal musculoskeletal physical examination with full range of motion in all joints, and a normal gait.

122. On or about December 18, 2018, Respondent noted in Patient F's records that he planned to discontinue alprazolam and hydrocodone on the following visit. Respondent did not document any plan for tapering the medications, but noted that Patient F should be referred to a pain management specialist.

123. In 2018, Patient F presented to Respondent's clinic for treatment approximately 15 times, meeting with Respondent each time.

124. During the period of on or about January 22, 2018 through December 11, 2018, Patient F filled the following prescriptions for controlled substances:

Date Filled	Drug Name	Form	Drug Strength	Qty	Days' Supply	Prescriber Name
1/22/2018	ALPRAZOLAM	TAB	1 MG	60	20	Respondent
1/22/2018	HYDROCODONE BITARTRATE-ACETAMINOPHEN	TAB	325 MG-10 MG	120	20	Respondent
2/20/2018	ALPRAZOLAM	TAB	1 MG	60	20	Respondent
2/20/2018	HYDROCODONE BITARTRATE-ACETAMINOPHEN	TAB	325 MG-10 MG	120	20	Respondent
3/20/2018	ALPRAZOLAM	TAB	1 MG	60	20	Respondent
3/20/2018	HYDROCODONE BITARTRATE-ACETAMINOPHEN	TAB	325 MG-10 MG	120	20	Respondent
4/16/2018	ALPRAZOLAM	TAB	1 MG	60	20	Respondent
4/16/2018	HYDROCODONE BITARTRATE-ACETAMINOPHEN	TAB	325 MG-10 MG	120	20	Respondent
5/15/2018	ALPRAZOLAM	TAB	1 MG	60	20	Respondent
5/15/2018	HYDROCODONE BITARTRATE-ACETAMINOPHEN	TAB	325 MG-10 MG	120	20	Respondent
6/15/2018	ALPRAZOLAM	TAB	1 MG	60	20	Respondent
6/15/2018	HYDROCODONE BITARTRATE-ACETAMINOPHEN	TAB	325 MG-10 MG	120	30	Respondent
7/17/2018	ALPRAZOLAM	TAB	1 MG	60	20	Respondent
7/17/2018	HYDROCODONE BITARTRATE-ACETAMINOPHEN	TAB	325 MG-10 MG	120	20	Respondent
8/15/2018	ALPRAZOLAM	TAB	1 MG	60	20	Respondent

Date Filled	Drug Name	Form	Drug Strength	Qty	Days' Supply	Prescriber Name
8/15/2018	HYDROCODONE BITARTRATE-ACETAMINOPHEN	TAB	325 MG-10 MG	120	20	Respondent
9/12/2018	ALPRAZOLAM	TAB	1 MG	60	20	Respondent
9/12/2018	HYDROCODONE BITARTRATE-ACETAMINOPHEN	TAB	325 MG-10 MG	120	20	Respondent
10/10/2018	ALPRAZOLAM	TAB	0.5 MG	50	16	Respondent
10/10/2018	HYDROCODONE BITARTRATE-ACETAMINOPHEN	TAB	325 MG-10 MG	120	20	Respondent
10/10/2018	ZOLPIDEM TARTRATE	TAB	5 MG	30	30	Respondent
10/15/2018	ALPRAZOLAM	TAB	1 MG	60	20	Respondent
11/7/2018	ALPRAZOLAM	TAB	1 MG	60	20	Respondent
11/7/2018	HYDROCODONE BITARTRATE-ACETAMINOPHEN	TAB	325 MG-10 MG	120	20	Respondent
11/7/2018	ZOLPIDEM TARTRATE	TAB	5 MG	30	30	Respondent
12/11/2018	ALPRAZOLAM	TAB	1 MG	60	20	Respondent
12/11/2018	HYDROCODONE BITARTRATE-ACETAMINOPHEN	TAB	325 MG-10 MG	120	20	Respondent
12/11/2018	ZOLPIDEM TARTRATE	TAB	5 MG	30	30	Respondent

2019

125. In 2019, Patient F presented to Respondent's clinic for treatment approximately 4 times, meeting with Respondent each time.

126. During the period of on or about January 10, 2019 through May 22, 2019, Patient F filled the following prescriptions for controlled substances:

Date Filled	Drug Name	Form	Drug Strength	Qty	Days' Supply	Prescriber Name
1/10/2019	HYDROCODONE BITARTRATE-ACETAMINOPHEN	TAB	325 MG-10 MG	120	20	Respondent
1/16/2019	LORAZEPAM	TAB	1 MG	12	4	M.H., M.D.
1/28/2019	ALPRAZOLAM	TAB	1 MG	12	12	J.M., M.D.
2/4/2019	ALPRAZOLAM	TAB	0.5 MG	30	10	Respondent
2/8/2019	HYDROCODONE BITARTRATE-ACETAMINOPHEN	TAB	325 MG-10 MG	90	15	Respondent
2/14/2019	ALPRAZOLAM	TAB	0.5 MG	30	10	Respondent
4/17/2019	HYDROCODONE BITARTRATE-ACETAMINOPHEN	TAB	325 MG-10 MG	90	30	T.M.
5/22/2019	HYDROCODONE BITARTRATE-ACETAMINOPHEN	TAB	325 MG-10 MG	90	30	T.M.

Departures: Patient F

127. Respondent did not adequately document the characterization Patient F's pain including etiology, location, radiation, intensity, relieving and aggravating factors, and impact on

his quality of life. Respondent's medical records for Patient F consist of templated forms, with significant discrepancies between the information documented in the history of presenting illness, and the physical examination. Respondent frequently included repeated identical findings at each visit, and failed to record evidence in physical examinations to substantiate the diagnoses for Patient F's chronic pain and anxiety. Respondent's failure to adequately and accurately document the physical examination at each visit for Patient F constituted a separate and distinct departure from the standard of care.

128. Respondent prescribed Patient F a combination of opioids in combinations with carisoprodol, which carries a risk of respiratory depression, overdose and death. Respondent did not adequately assess the benefits, harms, pain and functional improvements, consideration of alternative non-opioid modalities, utilization of urine drugs screens or review of CURES reports while prescribing controlled substances to Patient F. Respondent's prescribing of controlled substances to Patient F constitutes a departure from the standard of care, and demonstrates a lack of knowledge.

129. Respondent did not utilize a step wise approach in the treatment and prescribing related to Patient F's prescriptions for benzodiazepines. Patient F was already receiving benzodiazepines from another provider when she presented to Respondent, who elected to continue the prescriptions. Respondent did not document the justification for continuing the benzodiazepine prescriptions. Respondent did not document any consideration of using long acting rather than short acting benzodiazepines for Patient F, which typically have less potential for addiction. Respondent did not document any consideration or attempt at treating Patient E's anxiety with non-controlled medications. Respondent's use of benzodiazepines in the treatment of Patient F's anxiety constituted a departure from the standard of care, and demonstrated a lack of knowledge.

130. Respondent utilized unaltered templates during nearly all visits with Patient F, without updating the patient record to reflect changes in her condition, which constituted a departure from the standard of care.

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131. Respondent repeatedly documented inadequate, conflicting information related to Patient F's mobility in the history of presenting illness and physical examine sections of the medical record. Respondent's inaccurate documentation and insufficient evidence fail to provide subsequent providers with information necessary to determine if a physical examination was even conducted on each visit. Each instance of Respondent's failure to adequately and accurately document the record each occurrence represents a separate and distinct departure from the standard of care.

SECOND CAUSE FOR DISCIPLINE

(Failure to Maintain Adequate Medical Records)

132. Respondent is subject to disciplinary action under section 3527, as defined by section 2266, of the Code, in that he failed to maintain adequate and accurate records in connection with his care and treatment of Patient A, Patient B, Patient C, Patient D, Patient E, and Patient F, as more particularly alleged in paragraphs 30 through 131, which are hereby incorporated by reference and realleged as if fully set forth herein.

THIRD CAUSE FOR DISCIPLINE

(Incompetence)

133. Respondent Stanton Herrick Brown, P.A. is subject to disciplinary action under section 3527, as defined by section 2234, subdivision (d), in that he demonstrated incompetence in the care and treatment of Patient A, Patient C, Patient D, and Patient F, as more particularly alleged in paragraphs 30 through 131, which are hereby incorporated by reference and realleged as if fully set forth herein.

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PRAYER

WHEREFORE, Complainant requests that a hearing be held on the matters herein alleged, and that following the hearing, the Physician Assistant Board issue a decision:

1. Revoking or suspending Physician Assistant License Number PA 11937, issued to Stanton Herrick Brown, P.A.;

2. Ordering Stanton Herrick Brown, P.A., to pay the Physician Assistant Board the reasonable costs of the investigation and enforcement of this case, pursuant to Business and Professions Code section 125.3; and,

3. Taking such other and further action as deemed necessary and proper.

DATED: July 8, 2020

MAUREEN L. FORSYTH
Executive Officer
Physician Assistant Board
Department of Consumer Affairs
State of California
Complainant

FR2020301696